Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Orthopedic Specialists

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-14-2989-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our practice performed an MRI on January 3, 2014, and received payment for that service on April 25, 2014 for $372.37. The payment was approximately seventy per cent reduction from the State of Illinois fee schedule for the service ($1,213.79).

…I was informed that the State of Texas Workers Compensation program reimburses out of state services at 200% of the local Medicare Fee Schedule. To document the amount in dispute, I have included a copy of a Medicare voucher for another patient who received the same service in January 2014. You will observe that the Allowed amount is $274.09. I arrived at the Amount in Dispute by doubling the $274.09 ($548.18), and subtracting the amount previously paid ($372.37) to arrive at the $175.81 disputed amount."

Amount in Dispute: $175.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that the bill was paid correctly.

The provider is **incorrect** in their statement that they should receive 200% above Medicare. That pricing methodology typically refers to facility billing. When performing a pricing look up the payment the provider received is correct. Please see calculation below:

For code 73221 as of 1/1/2014 the par fee is $239.27

2014 TX CF $55.75
2014 Medi CF 35.8228

55.75/35.8228=1.5562

$239.27 x 1.5562 = $372.35 they system rounded up to $372.37 the code is paying correctly."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2014	MRI without contrast	$175.81	$54.19

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (W1) Workers Compensation State Fee Schedule Adjustment
   - 2 – The amount paid reflects a fee schedule reduction. (P300)
   - 4 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. What is the correct MAR for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Illinois to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. This dispute relates to professional medical services performed in an office setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203. Paragraph (b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…"

   Procedure code 73221, service date January 3, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.35 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 1.37565. The practice expense (PE) RVU of 5.72 multiplied by the PE GPCI of 1.065 is 6.0918. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 1.671 is 0.18381. The sum of 7.65126 is multiplied by the Division conversion factor of $55.75 for a MAR of $426.56.

   In the position statement from the insurance provider, the respondent included a calculation that utilized Medicare conversion factor 35.8228. However, this conversion factor is for Texas. The services were performed in Illinois, so geographic values were based on this location.
3. Review of the submitted documentation finds that the requestor billed $2600.00 for the services in dispute. The insurance carrier paid $372.37. The requestor is seeking a balance of $175.81. The total allowable of $426.56 minus the paid amount is $54.19. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $54.19.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $54.19 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	February 25, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.